

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12345

Reg. Dist. No.

12379

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u> c. LENGTH OF STAY IN 1b <u>30 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Dolphus</u> Middle <u>Adams</u> Last 4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>19 56</u>				5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-17-1890</u> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 9. AGE (In years last birthday) <u>66 yrs.</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u> 11. BIRTHPLACE (State or foreign country) <u>Renick, W. Va.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Thomas C. Adams</u> 14. MOTHER'S MAIDEN NAME <u>No information</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>188-07-4810</u> (If yes, give war or dates of service)				17. INFORMANT <u>Elsworth Adams</u> Address <u>Rising Sun, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound Fracture of skull, Fracture of neck</u> <u>812X</u> DUE TO <u>and left ankle and partial amputation of</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>right lower leg, laceration of scalp</u> DUE TO <u>multiple abrasions over body.</u> (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Hit by a car crossing road.</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>7.28 m. 12-15-56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 1</u>		20f. (City or town) <u>Harrisville</u> (County) <u>Cecil</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R. C. Dodson</u> EXAMINER'S NAME (Type) <u>R. C. Dodson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M. Reed</u>				ADDRESS <u>Rising Sun, Md.</u>		24a. REC'D BY REGISTRAR <u>Dec-18-56</u>	
24b. REGISTRAR'S SIGNATURE <u>DMN</u>				DATE SIGNED <u>12-17-56</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12346

12380

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 8yrs 7mos 29days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3424 - 13th St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle C. Last AMMON				4. DATE OF DEATH Month December Day 28 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 11, 1879	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.		IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Alton, Illinois	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW-1		17. INFORMANT Hospital Records, VAH., Perry Point, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential vascular or hypertension DUE TO (c) Arteriosclerosis generalized, severe						INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 1. Month 19 Day 19 Year 19 p. m. VA				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA	
20f. (City or town) VA				20g. (County) VA			
20h. (State) VA				20i. (State) VA			
21. I certify that I attended the deceased from April 29, 1948 to December 28, 1956 and that death occurred at 7:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA DATE SIGNED 12-30-56							
ACTUAL SIGNATURE William M. Harris				M.D. V.A. Hospital, Perry Point, Md. 12-30-56			
PHYSICIAN'S NAME (Type) WILLIAM M. HARRIS, M.D., Actg. Dir. Professional Services, VAH, Perry Point,							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-30-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Dougherty				ADDRESS James E. Dougherty		24a. REC'D BY REGISTRAR DATE 12-31-56	
24b. REGISTRAR'S SIGNATURE James E. Dougherty							

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1920		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1965		10:00 AM		St. Mary's Hospital		J. A. Smith, M.D.		J. B. Jones, Registrar	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Date of Last Medical Examination		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
Teacher		Married		Hypertension		Dec 1, 1964		Dec 1, 1964		Jan 15, 1965		10:00 AM		St. Mary's Hospital		J. A. Smith, M.D.		J. B. Jones, Registrar		J. A. Smith, M.D.		J. B. Jones, Registrar	
Usual Residence		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
Baltimore, Md.		Jan 15, 1965		10:00 AM		St. Mary's Hospital		J. A. Smith, M.D.		J. B. Jones, Registrar		J. A. Smith, M.D.		J. B. Jones, Registrar		J. A. Smith, M.D.		J. B. Jones, Registrar		J. A. Smith, M.D.		J. B. Jones, Registrar	

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CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 24yrs. 5mos. 4ds.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 3005 Eastern Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANK Middle ANTONIAK Last ANTONIAK		4. DATE OF DEATH Month December Day 30 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1892
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 30 Days 19 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-1		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, unresolved, left lower lobe 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 5-6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general, severe - unknown		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 26, 1932 to December 30, 1956 and that death occurred at 12:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) Perry Point, Maryland	
DATE SIGNED 12-31-56			
PHYSICIAN'S NAME (Type) W. OPPLER, Director, Professional Services, VAH., Perry Point, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 12-31-56	22c. NAME OF CEMETERY OR CREMATORY Holy Rosary	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Ozazewski		ADDRESS 1930 Eastern Ave. Baltimore, Md.	
24a. REC'D BY REGISTRAR 3		24b. REGISTRAR'S SIGNATURE 1957	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1920		New York City		Natural		Heart Disease		Jan 15, 1965		Home		[Signature]		[Signature]	
Occupation		Education		Marital Status		Previous Illnesses		Last Medical Examination		Hospital Name		Hospital Address		Hospital City		Hospital State		Hospital Zip		Hospital Phone	
Teacher		High School		Married		None		Jan 10, 1965		St. Mary's Hospital		123 Main St		Baltimore		MD		21201		(410) 555-1234	
Date of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Place of Death		Signature of Physician	
Jan 15, 1965		Home		[Signature]		[Signature]		Jan 15, 1965		Home		[Signature]		[Signature]		Jan 15, 1965		Home		[Signature]	

BUREAU V. S.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>				d. STREET ADDRESS <u>112 Church St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HAMEL</u> Middle <u>-</u> Last <u>BOUCHELLE</u>				4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-30-1876</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TANITOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>CHARLES THOMAS BOUCHELLE</u>				14. MOTHER'S MAIDEN NAME <u>AMELIA PEARCE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. AMY M. BOUCHELLE</u>		Address <u>112 Church St., Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR THROMBOSIS</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL VASCULAR SCLEROSIS</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3-4 years</u> <u>6 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov 30</u> , 19 <u>58</u> , to <u>Dec 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 2</u> , 19 <u>58</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>154 W. MAIN ST. ELKTON, MD.</u> DATE SIGNED <u>12-2-58</u>							
ACTUAL SIGNATURE <u>Peter Stavrakis</u>				M.D. <u>154 W. MAIN ST. ELKTON, MD.</u>			
PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>December 5, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tiffin Memorial Home, P.R.</u>		22d. LOCATION (City, town, or county) (State) <u>R.D. Elkton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Pippin</u>				ADDRESS <u>259 E Main St Elkton Md</u>		24a. REC'D BY REGISTRAR <u>12/4/58</u>	
				24b. REGISTRAR'S SIGNATURE <u>J.R. Frazer</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 19

DEC 5

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12382

CERTIFICATE OF DEATH

12349

Reg. Dist. No. 94

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Miriam</u> Middle <u>Rose</u> Last <u>Boyer</u>				4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 25 1914</u>		9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coffee Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Herman Boyer</u>				14. MOTHER'S MAIDEN NAME <u>Mrytle Rose</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-01-7508</u>		17. INFORMANT Address <u>Mrs Mrytle R. Boyer North East, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>175X GENERAL CONSUMPTION, CIRCULATORY</u> DUE TO <u>FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>WIDESPEAD CANCER WITH MULTIPLE</u> DUE TO (c) <u>METASTASIS IN INTEST., LIVER, BONES ETC</u> app. 2 years						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 15, 1956</u> , to <u>Dec. 28, 1956</u> , that I last saw the deceased alive on <u>December 28 1956</u> , and that death occurred at <u>10:25 p. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Otto Vogel</u> M.D.				ADDRESS (Street, city or town, state) <u>North East</u> DATE SIGNED <u>12-28-56</u>			
PHYSICIAN'S NAME (Type) <u>OTTO VOGEL M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>North East Cecil Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph A. Fiant</u> ADDRESS <u>North East, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>Jan 2-57</u>		24b. REGISTRAR'S SIGNATURE <u>Sarah E. Pothornel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH _____		MARRIAGE _____	
DATE OF BIRTH _____		DATE OF DEATH _____	
SEX _____		RACE _____	
OCCUPATION _____		CAUSE OF DEATH _____	
PLACE OF DEATH _____		MEDICAL ATTENDANCE _____	
NAME OF DECEASED _____		NAME OF ATTENDING PHYSICIAN _____	
ADDRESS OF DECEASED _____		ADDRESS OF PHYSICIAN _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF WITNESS _____		SIGNATURE OF REGISTRAR _____	

BUREAU V. S.

JAN 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12365

CERTIFICATE OF DEATH

12350

Reg. Dist. No.

94

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Cecil.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cecilton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cecilton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>JOHN</i> Middle <i>W.</i> Last <i>BRAXTON</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>1</i> Year <i>1956</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 20 1883</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm labor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>VA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Delaware Braxton</i>		14. MOTHER'S MAIDEN NAME <i>Ester Barnett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-09-4868</i>	
17. INFORMANT <i>John Braxton</i> Address <i>Cecilton Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Inoperable esophageal hernia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>years</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Aug</i> , 1956, to <i>Dec 1</i> , 1956, that I last saw the deceased alive on <i>Dec 1</i> , 1956, and that death occurred at <i>2:30</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wallace Oberstain</i> M.D.		ADDRESS (Street, city or town, state) <i>Cecilton Md</i> DATE SIGNED <i>2 Dec 56</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Dec 4 1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Farmly Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>VA.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Helow</i> ADDRESS <i>Millington Md.</i>		24a. REC'D BY REGISTRAR <i>DEC 5 1956</i> 24b. REGISTRAR'S SIGNATURE <i>L.R. Hager</i>	

CERTIFICATE OF DEATH

12365

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of birth: <i>Jan 15, 1900</i></p>	
<p>5. Place of birth: <i>Baltimore, Md.</i></p>		<p>6. Usual residence: <i>123 Main St., Baltimore, Md.</i></p>	
<p>7. Cause of death: <i>Heart disease</i></p>		<p>8. Date of death: <i>Dec 10, 1935</i></p>	
<p>9. Place of death: <i>Home</i></p>		<p>10. Signature of physician: <i>[Signature]</i></p>	
<p>11. Signature of registrar: <i>[Signature]</i></p>		<p>12. Date of registration: <i>Dec 15, 1935</i></p>	

BUREAU V. S.

DEC 5 1935

RECEIVED

12383

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,				c. LENGTH OF STAY IN 1b 2mos. 22days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORTHEAST				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle E Last BROWN				4. DATE OF DEATH Month December Day 31, Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 18, 1907		9. AGE (In years last birthday) yrs. 49	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Shoe		11. BIRTHPLACE (State or foreign country) Pueblo, Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM D. BROWN				14. MOTHER'S MAIDEN NAME FLORENCE LOCKIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records, VA Hospital, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, squamous cell type, floor of mouth, left DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4-5 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. Month, Day, Year p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 9 , 19 56 , to December 31, 1956 and that death occurred at 1:15A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Perry Point, Maryland DATE SIGNED 12-31-56 ACTUAL SIGNATURE W. Oppler M.D. W. OPPLER, M. D., Director, Professional Services, VAH., Perry Point, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 12-31-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Harold De Grace, Md.				24a. REC'D BY REGISTRAR DATE 1-4-57		24b. REGISTRAR'S SIGNATURE Inez E. Dougherty	

$$x \rightarrow y \quad \text{if and only if} \quad x \leq y \text{ and } y \leq x$$

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BUREAU V. 5

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12352

12384

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENN. b. COUNTY CHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NOTTINGHAM	
c. LENGTH OF STAY IN 1b 6 Mo.		d. STREET ADDRESS ROUTE # 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First ANDREW Middle BUCHANAN Last BUCHANAN		4. DATE OF DEATH Month DECEMBER Day 9 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 1, 1878
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY MILK PLANT	
11. BIRTHPLACE (State or foreign country) NOTTINGHAM, PA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ANDREW BUCHANAN		14. MOTHER'S MAIDEN NAME KATHARINE ST CLAIR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-05-8938	
17. INFORMANT WILMER BUCHANAN		Address PERRY POINT, MD.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatous (c) Cachexia		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 1956 to Dec 9, 1956 , that I last saw the deceased alive on Dec 9, 1956 , and that death occurred at 3 P. M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Charles J. Filly	DATE SIGNED 12/10/56
PHYSICIAN'S NAME (Type) Harold D. Smith	

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/12/56	22c. NAME OF CEMETERY OR CREMATORY FREEMONT	22d. LOCATION (City, town, or county) (State) NOTTINGHAM PA.
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23. FUNERAL DIRECTOR'S SIGNATURE Ralph M Reed	ADDRESS Ring Sun, Md.	24a. REC'D BY REGISTRAR DATE 12/10/56	24b. REGISTRAR'S SIGNATURE June E. Daugherty
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12385 CERTIFICATE OF DEATH

12353

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,		c. LENGTH OF STAY IN 1b 29yrs2mos26days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARLINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital			d. STREET ADDRESS 2922 N. Glebe Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HARRY Middle ROLAND Last BUCKLEY			4. DATE OF DEATH Month December Day 24 Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1890	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Gainsville, Virginia	
13. FATHER'S NAME William A. Buckley			14. MOTHER'S MAIDEN NAME Mabelle Simpson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW-I		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records, VAH., Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial fibrosis left ventricular wall DUE TO Coronary sclerosis, severe (c) arteriosclerosis generalized, severe					INTERVAL BETWEEN ONSET AND DEATH 1 day Unknown Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 28, 1957 to December 24, 1956 and that death occurred at 2:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE Joseph C. Grasberger M.D. VAH., Perry Point, Maryland					
PHYSICIAN'S NAME (Type) J. C. GRASBERGER, M.D., Actg. Director Professional services, Perry Point, Md.					
22a. BURIAL, CREMATION, REMOVAL REMOVAL		22b. DATE THEREOF 12-27-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
				22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Edwin J. DeGrace			24a. REC'D BY REGISTRAR DATE 12-24-56		
ADDRESS Havre DeGrace, Md.			24b. REGISTRAR'S SIGNATURE Gene E. Dougherty		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12386

CERTIFICATE OF DEATH

12354

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo Rural		c. LENGTH OF STAY IN 1b 4 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Helen Middle Elaine Last Burton		4. DATE OF DEATH Month Dec. Day 8 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1956
9. AGE (In years last birthday) yrs. 4		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Burton		14. MOTHER'S MAIDEN NAME Marie Willen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John F. Burton		Address Conowingo, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Broncho Pneumonia 48 hours 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-6-56, 19, to 12-8-56, 19, that I last saw the deceased alive on 12-6-56, 19, and that death occurred at 5 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Cecil Co. Md. DATE SIGNED 12-8-56 ACTUAL SIGNATURE R. C. Dodson M.D. PHYSICIAN'S NAME (Type) R. C. Dodson, M.D. Rising Sun, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 10, 1956	
22c. NAME OF CEMETERY OR CREMATORY Hopewell Cem.		22d. LOCATION (City, town, or county) (State) Near Port Deposit, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson Rising Sun, Md.		24a. REC'D BY REGISTRAR 12/10/56	
24b. REGISTRAR'S SIGNATURE L. M. Northington		2065330XV6	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. PLACE OF BIRTH		6. DATE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		MALE		35		WHITE		MEMPHIS, TENN.		JAN 17, 1928		JUN 6, 1968		MEMPHIS, TENN.		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. SOCIAL SECURITY NUMBER		18. MARITAL STATUS		19. RELIGION		20. SOCIAL SECURITY NUMBER		21. MARITAL STATUS		22. RELIGION		23. SOCIAL SECURITY NUMBER		24. MARITAL STATUS	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		000-00-0000		MARRIED		METHODIST		000-00-0000		MARRIED		METHODIST		000-00-0000		MARRIED	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

DEC 12 1956

RECEIVED

12366

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>9 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ABEL</u> Middle <u>C</u> Last <u>CAMERON</u>				4. DATE OF DEATH Month <u>December</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1875</u>		9. AGE (In years last birthday) yrs. <u>81</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Manufacture</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fire Brick</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Nelson Cameron</u>				14. MOTHER'S MAIDEN NAME <u>Annie L. Craig</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-05-6870</u>		17. INFORMANT <u>J. Nelson Cameron</u> Address <u>North East, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>001X</u> DUE TO <u>ACUTE HEART INSUFFICIENCY</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. <u>SILICOSIS + INVETERATED</u> <u>INACTIVE LUNG-TUBERCULOSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u> <u>10 years</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV. 1, 1956</u> to <u>Dec 14, 1956</u> , that I last saw the deceased alive on <u>Dec 13, 56, 19</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>NORTH EAST</u> DATE SIGNED <u>12-15-56</u> ACTUAL SIGNATURE <u>Otto Vogel</u> M.D. <u>OTTO VOGEL, MD</u> PHYSICIAN'S NAME (Type) <u>OTTO VOGEL, MD</u> <u>NORTH EAST</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-17-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>North East, Cecil Co, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph A. Grant</u> ADDRESS <u>North East, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>Dec 17</u>		24b. REGISTRAR'S SIGNATURE <u>IR Frazier</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Date of Registration		12. Office of Registrar	
13. Name of Informant		14. Relationship to Deceased		15. Signature of Informant	
16. Name of Informant		17. Relationship to Deceased		18. Signature of Informant	
19. Name of Informant		20. Relationship to Deceased		21. Signature of Informant	
22. Name of Informant		23. Relationship to Deceased		24. Signature of Informant	
25. Name of Informant		26. Relationship to Deceased		27. Signature of Informant	
28. Name of Informant		29. Relationship to Deceased		30. Signature of Informant	
31. Name of Informant		32. Relationship to Deceased		33. Signature of Informant	
34. Name of Informant		35. Relationship to Deceased		36. Signature of Informant	
37. Name of Informant		38. Relationship to Deceased		39. Signature of Informant	
40. Name of Informant		41. Relationship to Deceased		42. Signature of Informant	
43. Name of Informant		44. Relationship to Deceased		45. Signature of Informant	
46. Name of Informant		47. Relationship to Deceased		48. Signature of Informant	
49. Name of Informant		50. Relationship to Deceased		51. Signature of Informant	
52. Name of Informant		53. Relationship to Deceased		54. Signature of Informant	
55. Name of Informant		56. Relationship to Deceased		57. Signature of Informant	
58. Name of Informant		59. Relationship to Deceased		60. Signature of Informant	
61. Name of Informant		62. Relationship to Deceased		63. Signature of Informant	
64. Name of Informant		65. Relationship to Deceased		66. Signature of Informant	
67. Name of Informant		68. Relationship to Deceased		69. Signature of Informant	
70. Name of Informant		71. Relationship to Deceased		72. Signature of Informant	
73. Name of Informant		74. Relationship to Deceased		75. Signature of Informant	
76. Name of Informant		77. Relationship to Deceased		78. Signature of Informant	
79. Name of Informant		80. Relationship to Deceased		81. Signature of Informant	
82. Name of Informant		83. Relationship to Deceased		84. Signature of Informant	
85. Name of Informant		86. Relationship to Deceased		87. Signature of Informant	
88. Name of Informant		89. Relationship to Deceased		90. Signature of Informant	
91. Name of Informant		92. Relationship to Deceased		93. Signature of Informant	
94. Name of Informant		95. Relationship to Deceased		96. Signature of Informant	
97. Name of Informant		98. Relationship to Deceased		99. Signature of Informant	
100. Name of Informant		101. Relationship to Deceased		102. Signature of Informant	

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DEC 20 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12387

CERTIFICATE OF DEATH

12356

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Locust Pt. RFD				d. STREET ADDRESS Locust Pt. RFD No. 2			
3. NAME OF DECEASED (Type or print) First M. Middle ROSS Last CAUSEY				4. DATE OF DEATH Month Dec. Day 5 Year 1956			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1903	9. AGE (In years lost birthday) yrs. 53	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lewis M. Causey				14. MOTHER'S MAIDEN NAME Minnie H. -- (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-05-569		17. INFORMANT Address Mrs. Ruby T. Causey-RED #2 Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant brain tumor (Glioma -st) 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH About 8 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 9 , 19 56 , to Deaths 5 , 19 56 , that I last saw the deceased alive on Deaths 5 , 19 56 , and that death occurred at 2:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews Jr.		M.D. 233 E. Main St., Elkton, Md.		ADDRESS (Street, city or town, state)		DATE SIGNED 12/5/56	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS JR, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/56		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edm. J. Vickers & Sons - Balto 17, Md.				24a. REC'D BY REGISTRAR DATE Dec. 10, 1956		24b. REGISTRAR'S SIGNATURE L. R. Fugate	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12388

CERTIFICATE OF DEATH

12357

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 14yrs.8mo.10days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS 1014 Hewitt Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JAMES Middle C. Last DOTSON			4. DATE OF DEATH Month December Day 4 Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-8-95		9. AGE (In years last birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Tennessee	
13. FATHER'S NAME Ulysses G. Dotson			14. MOTHER'S MAIDEN NAME Mary Alice Wright		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW I		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis, pulmonary, far advanced, right 002X DUE TO upper lobe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general, moderate unknown					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 24, 1942, to December 4, 1956, that I saw the deceased alive on 12-6-56 and that death occurred at 8:50a.M. from the causes and on the date stated above. W. Appleton ADDRESS (Street, city or town, state) DATE SIGNED M.D. V.A. Hospital, Perry Point, Md. 12-6-56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) W. OPPLER Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-6-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		ADDRESS		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24a. REC'D BY REGISTRAR DATE 12-9-56		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty			

DEC 11 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12358

12367

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY <u>Loecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Loecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>945 W. High Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mabel Sophia Ehlers</u>				4. DATE OF DEATH <u>Dec. 20</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 14 1870</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Elkton-Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Alexander M. Knight</u>				14. MOTHER'S MARRIED NAME <u>Sophia Letton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Marjorie Sarkin - Elkton-Md daughter</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis.</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>about 5 yrs</u> <u>unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 20</u> , 19 <u>56</u> , to <u>Dec 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 19</u> , 19 <u>56</u> , and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>113 Bridge Street Elkton - Maryland</u> DATE SIGNED							
ACTUAL SIGNATURE <u>V. H. McKnight</u> M.D.							
PHYSICIAN'S NAME (Type) <u>V. H. McKnight</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-23-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. Henry Pappin</u> ADDRESS <u>259 E. Main St Elkton, Md.</u>				24a. REC'D BY REGISTRAR <u>Dec 27</u>		24b. REGISTRAR'S SIGNATURE <u>FR Fraser</u>	

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DEC 23 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12389

CERTIFICATE OF DEATH

12359

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural				c. LENGTH OF STAY IN 1b 37 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Peter Nicklas Hansen				4. DATE OF DEATH Dec. 29 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1873	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired Farmer		Owner		Shesvieg Holstein Germany		U.S.	
13. FATHER'S NAME Nicklas Hansen				14. MOTHER'S MAIDEN NAME Matilda Claussen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Harry W. Hansen Address North East, Md. Box 44			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 12-18-56 , 19____, to 12-28-56 , 19____, that I last saw the deceased alive on 12-28-56 , 19____, and that death occurred at 11.15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 12-29-56							
ACTUAL SIGNATURE R. C. Dodson M.D. Rising Sun, Md.							
PHYSICIAN'S NAME (Type) R. C. Dodson M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 31, 1956	22c. NAME OF CEMETERY OR CREMATORY Hopewell Cem.	22d. LOCATION (City, town, or county) (State) Near Port Deposit Md.				
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson ADDRESS Rising Sun, Md.			24. REC'D BY REGISTRAR Dec 31-16	25. REGISTRAR'S SIGNATURE L. M. Worthington			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12360

12368

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md. c. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colora Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Jennie Heyberger		4. DATE OF DEATH December 12 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2 1863
9. AGE (In years last birthday) 95		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housework		10b. KIND OF BUSINESS OR INDUSTRY General Housework	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Heyberger		14. MOTHER'S MAIDEN NAME No information	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Maud Ewing		Address Colora, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181X Carcinoma of the Bladder DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 10 1956, to 12-11-56, 19, that I last saw the deceased alive on 12-11, 1956, and that death occurred at 5 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. L. Dodson M.D.		ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 12-14-56	
PHYSICIAN'S NAME (Type) R. C. Dodson, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 16, 1956	
22c. NAME OF CEMETERY OR CREMATORY Brookview Cem.		22d. LOCATION (City, town, or county) (State) Rising Sun Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson		ADDRESS Rising Sun, Md. DATE Dec 17	
24a. REG'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE H. H. Trager	

BUREAU V. S.

DEC 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12390

CERTIFICATE OF DEATH

12361

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 1 mo. 28 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, 47x3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS 29-46th St., S.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last William James Hudson			4. DATE OF DEATH Month Day Year December 21, 1956		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-19	9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist helper		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Macon, Ga.	
13. FATHER'S NAME John Hudson			14. MOTHER'S MAIDEN NAME Hattie Green		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes. WWI		16. SOCIAL SECURITY NO. 261 14 5561		17. INFORMANT VAH, Records, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia, bilateral, unresolved 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis, bilateral, severe DUE TO Prostatic hypertrophy (c) Urethral stricture					INTERVAL BETWEEN ONSET AND DEATH 4 - 5 days Unknown Unknown Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from October 23, 1956 , to December 21, 1956 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED E. S. ELLS, M.D. V. A. Hospital, Perry Point, Md. 12/23/56					
ACTUAL SIGNATURE E. S. ELLS					
PHYSICIAN'S NAME (Type) E. S. ELLS, M.D., Acting Director, Professional Services, VAH, Perry Point, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-24-56		22c. NAME OF CEMETERY OR CREMATORY DUVAL CEMETERY	
22d. LOCATION (City, town, or county) (State) Jacksonville, Florida					
23. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON, Hayre de Grace, Maryland.		ADDRESS		24a. REC'D BY REGISTRAR DATE 12-23-56	
24b. REGISTRAR'S SIGNATURE Irene E. Daugherty					

CERTIFICATE OF DEATH

35

NAME OF DECEASED Gail		DATE OF DEATH 12-27-53	
AGE 28 years		SEX Female	
PLACE OF BIRTH Washington, D.C.		DATE OF BIRTH 12-27-25	
HUSBAND James		DATE OF MARRIAGE 12-27-48	
RESIDENCE 12-27-53		PLACE OF DEATH Washington, D.C.	
CAUSE OF DEATH Hypertension, bilateral, unsymmetrical		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. A. Jones		SIGNATURE OF REGISTRAR J. A. Jones	
DATE OF SIGNATURE 12-27-53		DATE OF SIGNATURE 12-27-53	
PLACE OF SIGNATURE Washington, D.C.		PLACE OF SIGNATURE Washington, D.C.	
DATE OF DEATH 12-27-53		DATE OF DEATH 12-27-53	
PLACE OF DEATH Washington, D.C.		PLACE OF DEATH Washington, D.C.	
CAUSE OF DEATH Hypertension, bilateral, unsymmetrical		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. A. Jones		SIGNATURE OF REGISTRAR J. A. Jones	
DATE OF SIGNATURE 12-27-53		DATE OF SIGNATURE 12-27-53	
PLACE OF SIGNATURE Washington, D.C.		PLACE OF SIGNATURE Washington, D.C.	

BUREAU V. S.

DEC 27 1953

RECEIVED

TO BE COMPLETED BY THE REGISTRAR PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT WITHIN 72 HOURS AFTER DEATH.

12391

12362

Reg. Dist. No. 96

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12362

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1647 Shadyside Road	
3. NAME OF DECEASED (Type or print) GEORGE THOMAS KIRK		4. DATE OF DEATH Month December Day 17 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 17, 1893
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 17 Days 19 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY City of Balto.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM H. KIRK		14. MOTHER'S MAIDEN NAME ELZRINA COPELAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I	
17. INFORMANT Hospital Records, VAH., Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general - unknown		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 13, 1951 , to December 17, 1956 , and that death occurred at 8:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. A. Hospital, Perry Point, Md.		DATE SIGNED 12-18-56	
PHYSICIAN'S NAME (Type) W. OPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-18-56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS, North & Penna. Ave; Balto., Md.		24a. REC'D BY REGISTRAR 12/20/56	
ADDRESS		24b. REGISTRAR'S SIGNATURE Irene Daugherty	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		APRIL 14, 1924		MOBILE, ALABAMA	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
FARMER		HEART DISEASE		SUICIDE		AT HOME		APRIL 4, 1968	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY	
NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		CITY		STATE	
APRIL 4, 1968		10:00 AM		AT HOME		MEMPHIS		TENNESSEE	

RECEIVED
DEC 21 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12363

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 14 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital D.O.A.				d. STREET ADDRESS 426 North St.			
3. NAME OF DECEASED (Type or print) First Middle Last John Limnions				4. DATE OF DEATH Month Day Year 12 5 19 56			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 6, 1891		9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe maker		10b. KIND OF BUSINESS OR INDUSTRY Repairing shoes		11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Angeles Limnions				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Angeles Limnions, 426 North St. Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) R.C. Dodson				DATE SIGNED 12-5-56			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF Dec. 8, 1956		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph E. Hicks 103 Stockton Street, Elkton, Md.				24a. REC'D BY REGISTRAR DATE 12/8/56		24b. REGISTRAR'S SIGNATURE FR Frazier	

TO DEPUTY, MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. B.

DEC 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12364

12370

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, or institution; residence before admission) o. STATE Elkton City, Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Howard Lodge		4. DATE OF DEATH Dec - 17th 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1880
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Richard H. Lodge		14. MOTHER'S MAIDEN NAME Jane Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Ida Lodge - wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) General Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 22, 1956 to Dec 17th, 1956, that I last saw the deceased alive on Dec 22, 1956, and that death occurred at 11:05 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE W. H. McNeight M.D.		Elkton - Maryland	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-1956	
22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memo. Pk.		22d. LOCATION (City, town, or county) (State) R. D. Elkton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Biffin 259 E. Main St. Elkton, Md.		24a. REC'D BY REGISTRAR DATE Dec 21	
		24b. REGISTRAR'S SIGNATURE J. R. Frazier	

RECEIVED

DEC 28 1956

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, MD.
1956

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
DATE OF REGISTRATION: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12371

CERTIFICATE OF DEATH

Reg. Dist. No.

12365

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Maryland</u> b. COUNTY <u>Berkley County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Martinsburg, W. Va.</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>	
d. STREET ADDRESS <u>223 N. College Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>B.</u> Last <u>Owens</u>		4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1916</u>
9. AGE (In years lost birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Martinsburg, West Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Preston Shade</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Stotler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>236-16-3841</u>	
17. INFORMANT <u>Theo Shade-brother</u>		Address <u>Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetic coma -3 days. Uremia-unknown time.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1</u> , 1956, to <u>Dec 3</u> , 1956, that I last saw the deceased alive on <u>Dec 3</u> , 1956, and that death occurred at <u>6:30p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace Obenshain</u> M.D.		ADDRESS (Street, city or town, state) <u>Cecilton, Md</u> DATE SIGNED <u>3 Dec 56</u>	
PHYSICIAN'S NAME (Type) <u>Wallace Obenshain M.D.</u>		<u>Cecilton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 7, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Martinsburg, West Va.</u>	22d. LOCATION (City, town, or county) (State) <u>Martinsburg, West Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		24a. REC'D BY REGISTRAR DATE <u>12/4/56</u>	
24b. REGISTRAR'S SIGNATURE <u>IR Frazer</u>		24c. REGISTRAR'S SIGNATURE <u>IR Frazer</u>	

BUREAU V. S.

DEC 5 1976

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12366

Items 18&20 Film 209 1-8-57 ams

12392

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY HARTFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 324 N. Union Avenue	
3. NAME OF DECEASED (Type or print) First CHARLES Middle R. Lost PAHR		4. DATE OF DEATH Month December Day 10 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-88
9. AGE (In years lost birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipper		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Pahr		14. MOTHER'S MAIDEN NAME Dorothea A. Frainy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 219-104-023	
17. INFORMANT VAH Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and hydronephrosis (recurrent x 1 year) 902.0 DUE TO Lacerations of face Bilateral hydronephrosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Presumptive head injury (fall from porch)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11-29-56 p. m. 11		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Havre de Grace, Harf. Md. (County) (State)	
21. I certify that I attended the deceased from November 29, 19 56, to December 10, 19 56, that I last saw the deceased alive on 12-10-56, and that death occurred at 10:55 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 12-10-56	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-13-56	
22c. NAME OF CEMETERY OR CREMATORY Angel Hill		22d. LOCATION (City, town, or county) Havre de Grace, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. MADISON MITCHELL		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE 12-12-56		24b. REGISTRAR'S SIGNATURE Gene E. Dougherty	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

DATE OF ONSET

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF REINTERMENT

BUREAU V. B.

DEC 17 1956

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12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2. See: Birth Cert.

12372

CERTIFICATE OF DEATH

123672

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worshipper, Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hosp</u>				d. STREET ADDRESS <u>Worshipper, Elkton</u>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Leo</u> Last <u>Preverto</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 20, 1956</u>		9. AGE (In years lost birthday) <u>3</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Bernard Preverto</u>			
14. MOTHER'S MAIDEN NAME <u>Albee Milam</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Bernard Preverto R.R. # 3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adrenal failure</u> <u>773.5</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 Dec</u> , 19 <u>56</u> , to <u>23 Dec</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>23 Dec</u> , 19 <u>56</u> , and that death occurred at <u> </u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clifton R. Brooks</u> M.D.		ADDRESS (Street, city or town, state) <u>Union Hosp of Cecil Co</u> DATE SIGNED <u>24 Dec 56</u>					
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 27, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Blakes Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Blake, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald M. Lee</u>		ADDRESS <u>ELKTON, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>JP Frager</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12368

12373 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS R. F. D. # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Dorothy Ann Poore				4. DATE OF DEATH Month Day Year Dec. 22 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 5, 1926		9. AGE (In years lost birthday) yrs. 3	IF UNDER 1 YEAR Months Days Hours Min. 20	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Elkton		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Winfield Poore				14. MOTHER'S MAIDEN NAME Shirley Chadwick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT R. F. # 1 Winfield Poore Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO lying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH Dec. 20, 1956
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 21, 1956, to Dec. 22, 1956, that I last saw the deceased alive on Dec. 22, 1956, and that death occurred at 10:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Elkton, Md. Dec. 23, 1956							
ACTUAL SIGNATURE <u>Winfield H. Sprecher</u> M.D.				PHYSICIAN'S NAME (Type) <u>Elkton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-1956		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Poff</u> ADDRESS <u>2596 Main St. Elkton Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Dec 27</u>		24b. REGISTRAR'S SIGNATURE <u>JR Fraser</u>	

2065191X V4

BUREAU V. S.

DEC 28 1956

RECEIVED

12393

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last Ella India Reynolds				4. DATE OF DEATH Month Day Year Dec. 18 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1869	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Rising Sun, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Pierce				14. MOTHER'S MAIDEN NAME Sara Pierce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary Lawrence		Address Rising Sun,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 wks. 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1954 to 12/18 1956 that I last saw the deceased alive on 12/18 1956, and that death occurred at 9 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Neal Taylor M.D.				ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 12/19/56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF Dec 22, 1956		22c. NAME OF CEMETERY OR CREMATORY Brookview, Cem,		22d. LOCATION (City, town, or county) (State) Coloma, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson				ADDRESS Rising Sun, Md.		24b. REGISTRAR'S SIGNATURE L. M. Northington	
				24a. REC'D BY REGISTRAR DATE Dec 19/56			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12370
Reg. Dist. No. 96

12391			
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Mass. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boston 58 x - 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Parlor Car on train 171 P.R.R.		d. STREET ADDRESS 514 Masschutis Ave	
3. NAME OF DECEASED (Type or print) William First Middle Last 0 Sawyers		4. DATE OF DEATH Month 12 Day 11 Year 19 56	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-7-1906
		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Parlor Car Attend		10b. KIND OF BUSINESS OR INDUSTRY Pullman Co.	11. BIRTHPLACE (State or foreign country) Tenn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Wm. I Sawyers		14. MOTHER'S MAIDEN NAME Sallie Owens Nashville, Tenn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Address Laura Anderson 315 Neill Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from Peptic Ulcer 540.0 DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-13-56	22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery
		22d. LOCATION (City, town, or county) (State) Nashville, Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Perryville, Md.		24a. REC'D BY REGISTRAR DATE 12-13-56	
		24b. REGISTRAR'S SIGNATURE Irene E. Daugherty	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME (Last, First, Middle Initial)		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH (Immediate)		11. CAUSE OF DEATH (Underlying)		12. MANNER OF DEATH	
13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
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RECEIVED
DEC 17 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12371

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY Cecil MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) Elkton TOWN Elkton HOSPITAL OR INSTITUTION OR STREET ADDRESS 220 E. Main				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Cecil CITY (If outside corporate limits, write RURAL and give nearest town) Elkton TOWN Elkton STREET ADDRESS (If rural give location) 220 E. Main			
3. NAME OF DECEASED (Type or Print) (First) DeLancey (Middle) Scott (Last) Delancy Scott				4. DATE OF DEATH (Month) 12 (Day) 30 (Year) 19 56			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9-3-1887	9. AGE last birthday 69 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Town Treas.		10b. KIND OF BUSINESS OR INDUSTRY Town Official		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Scott				14. MOTHER'S MAIDEN NAME Rachael Wilson Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 2i8-32-9260		17. INFORMANT & ADDRESS Mrs. Dolly Scott, Elkton, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 199.8 IMMEDIATE CAUSE (A) Uremia ANTECEDENT CAUSE(S) DUE TO (B) Cancer of prostate and colon and DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) right kidney						INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-1-56, 19...p., to 12-30-56, 19...p., that I last saw the deceased alive on 12-30-56, 19..., and that death occurred at 4:03 M, from the causes and on the date stated above. SIGNATURE Alex Doelson M.D. ADDRESS (Street, city, town, state) Rising Sun Md. DATE SIGNED 12-31-56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/1/57		NAME OF CEMETERY OR CREMATORY Elkton Cemetery		LOCATION (City, town, or county) Elkton Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE FR Frager		25. FUNERAL DIRECTOR'S SIGNATURE H. Walter du Bose, Jr.		ADDRESS Elkton, Md.	
DATE Jan 1, 1957							

CERTIFICATE OF DEATH

Form 100-1

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, Day, Year)

4. Place of birth (City, State, Country)

5. Date of death (Month, Day, Year)

6. Time of death (Hour, Minute)

7. Cause of death (List all causes, beginning with immediate cause)

8. Manner of death (Natural, Accidental, Suicide, Homicide, Undetermined)

9. Signature of physician (Print name and sign)

10. Signature of medical examiner (Print name and sign)

11. Signature of coroner (Print name and sign)

12. Signature of registrar (Print name and sign)

13. Signature of funeral director (Print name and sign)

14. Signature of informant (Print name and sign)

15. Address of informant (Street, City, State, Zip)

16. Date of completion (Month, Day, Year)

17. Name of hospital (If applicable)

18. Name of nursing home (If applicable)

19. Name of residence (If applicable)

20. Name of place of death (If applicable)

21. Name of place of burial (If applicable)

22. Name of place of interment (If applicable)

23. Name of place of cremation (If applicable)

24. Name of place of disposition (If applicable)

25. Name of place of disposal (If applicable)

26. Name of place of final disposition (If applicable)

27. Name of place of final disposal (If applicable)

28. Name of place of final disposition (If applicable)

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47. Name of place of final disposal (If applicable)

48. Name of place of final disposition (If applicable)

BUREAU V. S.

JAN 3 1957

RECEIVED

2001-11-11 PM

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12372

12395

CERTIFICATE OF DEATH

Reg. Dist. No. 92

Item 89: 60" 2/27/57 L

1. PLACE OF DEATH COUNTY <i>Cecil</i> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Childs</i> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i> Cecil</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>Childs</i> OR TOWN STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>J. Bayard Scott</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>Dec 28 1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH <i>Nov 5 1872</i>
9. AGE last birthday <i>77</i> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if transient) <i>Retired U.S. Master</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Cecil County</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>J. Polk Scott</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ellen Chapman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <i>James P. Scott - son</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 17230 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C)		18. MEDICAL CERTIFICATION <i>Malnutrition from osteoarthritis about 55 yrs</i> <i>General arteriosclerosis</i> <i>unknown</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug 7 1956</i> , to <i>Dec 28 1956</i> , that I last saw the deceased alive on <i>Dec 27 1956</i> , and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>V. H. McLaughlin</i> M.D.		DATE SIGNED <i>Dec 28 1956</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12-31-1956</i>	
NAME OF CEMETERY OR CREMATORY <i>Cherry Hill Cemetery</i>		LOCATION (City, town, or county) (State) <i>Cherry Hill Md</i>	
24. REC'D BY REGISTRAR DATE <i>1/3/57</i>		REGISTRAR'S SIGNATURE <i>J. H. Frager</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>W. Henry Phipps</i>		ADDRESS <i>259 E. Main St. Elkton, Md.</i>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1957

Form 10-1-56

1. Name of deceased (Print or write full name)

2. Sex (M or F)

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Date of death

8. Time of death

9. Place of death

10. Cause of death (List all causes, beginning with the immediate cause)

11. Manner of death (Natural, Accidental, Suicide, Homicide, Undetermined)

12. Signature of attending physician

13. Signature of medical examiner

14. Signature of coroner

15. Signature of registrar

16. Signature of informant

17. Name of informant

18. Address of informant

19. Telephone number

20. Date of filing

21. File number

22. Date of filing

23. File number

24. Date of filing

25. File number

26. Date of filing

27. File number

28. Date of filing

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BUREAU V. 2

JAN 4 1957

RECEIVED

REPORTS

1. Name of deceased (Print or write full name)
2. Sex (M or F)
3. Race
4. Date of birth
5. Place of birth
6. Usual residence
7. Date of death
8. Time of death
9. Place of death
10. Cause of death (List all causes, beginning with the immediate cause)
11. Manner of death (Natural, Accidental, Suicide, Homicide, Undetermined)
12. Signature of attending physician
13. Signature of medical examiner
14. Signature of coroner
15. Signature of registrar
16. Signature of informant
17. Name of informant
18. Address of informant
19. Telephone number
20. Date of filing
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12373

12396

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 7 mos. 29 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
				d. STREET ADDRESS 830 Jefferson St., N.W.			
3. NAME OF DECEASED (Type or print) First Middle Last John Albert Smith				4. DATE OF DEATH Month Day Year December 22, 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-90		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt. Clerk			10b. KIND OF BUSINESS OR INDUSTRY Federal		11. BIRTHPLACE (State or foreign country) South Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Harry W. Smith, Jr.				14. MOTHER'S MAIDEN NAME Ada Wadsworth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW1 579 28 7014		17. INFORMANT Address VAH, Records, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia, bilateral, unresolved 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic brain disease manifested by cysts and areas of necrosis. DUE TO (c) Arteriosclerosis, generalized, severe.						INTERVAL BETWEEN ONSET AND DEATH 4-5 days Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. VA 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
					20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from April 23, 19 56 , to December 22, 19 56 and that death occurred at 2:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE E. S. Ellis				ADDRESS (Street, city or town, state) DATE SIGNED M.D. V. A. Hospital, Perry Point, Md. 12/23/56			
PHYSICIAN'S NAME (Type) E. S. ELLIS, Acting Director, Professional Services, VAH, Perry Point, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-23-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. HINES COMPANY				24a. REC'D BY REGISTRAR DATE 12-23-56		24b. REGISTRAR'S SIGNATURE Irene E. Daugherty	

CERTIFICATE OF DEATH

Name of Deceased		John	
Age		30	
Sex		Male	
Race		White	
Date of Birth		10-10-20	
Place of Birth		Baltimore, Md.	
Date of Death		12-27-26	
Place of Death		Baltimore, Md.	
Cause of Death		Pneumonia (primary), of lobar, unresolved	
Manner of Death		Natural	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

RECEIVED
 DEC 27 1926
 BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12374

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 311 Hollingworth Manor			
3. NAME OF DECEASED (Type or print) First Middle Last Carl Lee Speck				4. DATE OF DEATH Month Day Year 12 11 19 56			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-13-1925	9. AGE (In years last birthday) 31 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant V.A.Hosp.		10b. KIND OF BUSINESS OR INDUSTRY Attendant		11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luther Boyd Speck				14. MOTHER'S MAIDEN NAME Mary Lou England			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.2 215-32-9428		17. INFORMANT Address Mildred Speck. 311 Hollingworth, Manor Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound fracture Base of Skull also DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) right frontal bone through right eye DUE TO (c) Laceration of left side of neck.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car ran under a truck loaded with steel					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12-11-56 1:55 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40		20f. (City or town) (County) (State) North East Cecil Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 13, 1956		22c. NAME OF CEMETERY OR CREMATORY Principio Cemetery		22d. LOCATION (City, town, or county) (State) Principio Cecil Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks, Elkton, Md				24a. REC'D BY REGISTRAR DATE Dec 15		24b. REGISTRAR'S SIGNATURE H. H. Frazer	

DEC 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12376

CERTIFICATE OF DEATH

12375
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EIKTON</u>			c. LENGTH OF STAY IN 1b <u>15 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EIKTON</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION Hospital</u>				d. STREET ADDRESS <u>301 Hollingsworth Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>C.</u> Last <u>Taylor</u>				DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1906</u>		9. AGE (In years lost birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electr</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tidewater Inc</u>		11. BIRTHPLACE (State or foreign country) <u>Paint Creek, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SIDNEY TAYLOR</u>			14. MOTHER'S MAIDEN NAME <u>EDNA INGRAM</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>336-01-0113</u>		17. INFORMANT <u>MRS. DOROTHY GROVES, EIKTON, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>331x</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <u>Dec. 9</u> , 19 <u>56</u> , to <u>Dec. 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 11</u> , 19 <u>56</u> , and that death occurred at <u>3:30</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Milford H. Sprecher</u> M.D.				ADDRESS (Street, city or town; state) <u>Eikton, Md</u>		DATE SIGNED <u>Dec. 11, 1956</u>	
PHYSICIAN'S NAME (Type) <u>Milford H. Sprecher, EIKTON, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-16-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SUNSET MEMORIAL</u>		22d. LOCATION (City, town, or county) (State) <u>Charleston, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>			ADDRESS <u>Eikton, Md</u>		24a. REC'D BY REGISTRAR DATE <u>Dec 15</u>		
					24b. REGISTRAR'S SIGNATURE <u>J. H. Frazer</u>		

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
SIDNEY J. JONES		M		45		JAN 15 1905		BALTIMORE, MD	
MARRIAGE		DATE		PLACE		NAME		DATE	
MARRIED		JAN 15 1925		BALTIMORE		JONES		JAN 15 1925	
EDUCATION		SCHOOL		DEGREE		DATE		PLACE	
HIGH SCHOOL		BALTIMORE		B.S.		JAN 15 1925		BALTIMORE	
OCCUPATION		BUSINESS		DATE		PLACE		NAME	
BUSINESS		JAN 15 1925		BALTIMORE		JONES		JAN 15 1925	
CAUSE OF DEATH		DISEASE		DATE		PLACE		NAME	
HEART DISEASE		JAN 15 1925		BALTIMORE		JONES		JAN 15 1925	
MANNER OF DEATH		NATURAL		DATE		PLACE		NAME	
NATURAL		JAN 15 1925		BALTIMORE		JONES		JAN 15 1925	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME		DATE	
J. J. JONES		JAN 15 1925		BALTIMORE		JONES		JAN 15 1925	
SIGNATURE OF REGISTRAR		DATE		PLACE		NAME		DATE	
J. J. JONES		JAN 15 1925		BALTIMORE		JONES		JAN 15 1925	

BUREAU V. 3

DEC 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12376

Reg. Dist. No. 93

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East, Rural</u>			
c. LENGTH OF STAY IN Tb <u>11yrs</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Blanche Taylor</u>				4. DATE OF DEATH Month Day Year <u>12 27 19 56</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-26-1908</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>Russell Co. Va.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House keeping</u>		11. BIRTHPLACE (State or foreign country) <u>Russell Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Monk</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Charles Monk, Rising Sun, Md.</u>			
17. INFORMANT Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Nephritis</u> DUE TO (b) <u>Arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-27-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u>				24a. REC'D BY REGISTRAR <u>Dec 28-56</u>			
ADDRESS <u>Rising Sun, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>L. M. Northington</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

BUREAU V. 3

DEC 31 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G209 1-4-57 et

12377

CERTIFICATE OF DEATH

12377

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 65 Union Hospital				d. STREET ADDRESS 513 North Street			
3. NAME OF DECEASED (Type or print) First William Middle T. Vinsinger Last				4. DATE OF DEATH Month December Day 16 Year 1956			
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 8, 1972		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Clerk Court house		11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Vinsinger				14. MOTHER'S MAIDEN NAME Cordelia Strickland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address 513 North St. Mrs. Carrie W. Vinsinger, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cerebral hemorrhage with hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 years Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1, 1954, to Dec 16, 1956, that I last saw the deceased alive on Dec 15, 1956, and that death occurred at 4:50 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE S. Ralph Andrews Jr. M.D. 233 E. Main St. Elkton, Md. 12/17/56 PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 16, 1956		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 259 E. Main St. Elkton, Md.				24a. REC'D BY REGISTRAR DATE Dec 21		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. TIME OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. CAUSE OF DEATH [REDACTED]		8. MANNER OF DEATH [REDACTED]		9. MEDICAL HISTORY [REDACTED]	
10. OCCUPATION [REDACTED]		11. EDUCATION [REDACTED]		12. RELIGION [REDACTED]	
13. MARITAL STATUS [REDACTED]		14. SOCIAL HISTORY [REDACTED]		15. PREVIOUS ILLNESSES [REDACTED]	
16. PHYSICIAN'S SIGNATURE [REDACTED]		17. MEDICAL EXAMINER'S SIGNATURE [REDACTED]		18. CORONER'S SIGNATURE [REDACTED]	
19. COUNTY [REDACTED]		20. CITY [REDACTED]		21. STATE [REDACTED]	

BUREAU V. 8

DEC 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12378

12398

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 1yr. 9mos. 9days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2808 - 12th Street, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First ABNER Middle D. Last WHITE		4. DATE OF DEATH Month December Day 24 Year 56			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 21, 1887		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABNER WHITE				14. MOTHER'S MAIDEN NAME MARY C. GANT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW-I		16. SOCIAL SECURITY NO. 578-05-3820		17. INFORMANT Hospital Records, VAH., Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis, severe DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3-5 days Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral edema and congestion (Unknown) Arteriosclerosis, generalized, severe. ((Unknown))						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 15, 19 55 to December 24 19 56 , and that death occurred at 5:40A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph C. Grasperger		ADDRESS (Street, city or town, state) VAH., Perry Point, Maryland				DATE SIGNED 12-24-56	
PHYSICIAN'S NAME (Type) J. C. GRASBERGER, M. D., Acting Director, Professional Services, VAH., Perry Point, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 12-25-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE BRINTON & SON		ADDRESS Havre DeGrace, Md.		24a. REC'D BY REGISTRAR DATE 12-24-56		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12379

12399

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calvert</u>		c. LENGTH OF STAY IN 1b <u>1 Yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Graybeal Nursing Home</u>				d. STREET ADDRESS <u>Lock St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Emmit Thompson</u> First Middle Last <u>White</u>				4. DATE OF DEATH <u>Dec.</u> Month Day Year <u>1</u> <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 12 1868</u>		9. AGE (In years last birthday) <u>88</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegraph Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penn. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clinton Johnson White</u>				14. MOTHER'S MAIDEN NAME <u>Martha Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Bertha White</u> Address <u>Chesapeake City</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-15</u> , 19 <u>56</u> , to <u>12-1-56</u> , 19____, that I last saw the deceased alive on <u>11-30-56</u> , 19____, and that death occurred at <u>5 A.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u> DATE SIGNED <u>12-2-56</u> ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D. PHYSICIAN'S NAME (Type) <u>R. C. Dodson M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cecil Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter de Boer, Jr.</u>				ADDRESS <u>Elberton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>12/6/56</u>	
						24b. REGISTRAR'S SIGNATURE <u>L. M. Worthington</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12380

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CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 2 days 8 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 304 King Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) C. Raymond				4. DATE OF DEATH Dec. 9 1956		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18, 1891		9. AGE (In years lost birthday) yrs. 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CECIL COUNTY SCHOOL BD Engineer				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME C. Wilmer Witworth				14. MOTHER'S MAIDEN NAME Ella L. Pierson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Mrs. Elsie Witworth 304 King St. Elkton			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (c)						INTERVAL BETWEEN ONSET AND DEATH 12/7	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 17, 1956, to Dec. 9, 1956, that I last saw the deceased alive on Dec. 9, 1956, and that death occurred at 10:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Elkton, Md. DATE SIGNED Dec. 9-1956 ACTUAL SIGNATURE Milford H. Sprecher M.D. PHYSICIAN'S NAME (Type) Milford H. Sprecher Elkton, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 12/56		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cherry Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks, 103 Stockton St. Elkton				24a. REC'D BY REGISTRAR DATE Dec 12		24b. REGISTRAR'S SIGNATURE JR Frazee	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

FILE NO.

1957

MARYLAND

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

TIME OF DEATH

AGE

SEX

MARITAL STATUS

EDUCATION

OCCUPATION

RELIGION

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12381

Reg. Dist. No. 95

12400

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Cecil Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calvert</u>			c. LENGTH OF STAY IN 1b <u>all life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calvert</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Georgia</u> Middle <u>S</u> Last <u>Worrilow</u>				4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-1889</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Keeping house</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mitchell Vandegrift</u>				14. MOTHER'S MAIDEN NAME <u>Phoebe Sapp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Joseph Worrilow, Nottingham, P.D. Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ </div> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ </div>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				DATE SIGNED <u>12-19-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-21-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friends</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert, Cecil Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R Grant North East Md</u>				24a. REC'D BY REGISTRAR <u>Dec 20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Lim Nottingham</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEC 26 1956